Credentialing

Because The Health Plan is a state and federally qualified health maintenance organization (HMO), it is required to comply with Quality Assurance Standards on credentialing, in addition to complying with the state of West Virginia, state of Ohio, CMS, and Ohio HB125 Credentialing Guidelines.

The initial credentialing process Includes:

- Facility onsite survey of primary care physician’s
- In addition to primary care physicians a facility site survey will be performed on obstetrics (OB)/gynecologists (GYN), and designated high-volume specialists who provide services to West Virginia Medicaid recipients
- Medical record review
- Physician application
- Provider Ownership Disclosure Form

Copies and verification of:

- Licensure(s)
- Clinical privileges
- DEA registration
- Complete malpractice history
- Board certifications

As any of these areas expire, a letter will be generated requesting a copy of the renewal. It is imperative that we receive this information as quickly as possible.

Practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.
Recredentialing

The Health Plan of the Upper Ohio Valley, Inc. recredentials all practitioners every three years.

This recredentialing process includes primary verification of:

- Licensure(s)
- Clinical privileges
- Valid DEA
- Board certification
- Adequate malpractice insurance
- Professional liability claims history
- Reappointment application
- Verifying the information contained on the reappointment application
- Provider Ownership Disclosure Form
- Facility site visit of PCP, OB/GYN, and designated high-volume specialists who provide services to WV Medicaid recipients if the site has not been previously reviewed as part of the credentialing process as well as every three years.
Practitioner’s Credentialing/Recredentialing Rights

- Practitioner has the right to correct erroneous information.
- Practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application.
- Practitioner has the right to review all information submitted to The Health Plan in support of the credentialing/recredentialing application.

**WV Practitioners:** The mandatory state of West Virginia Credentialing and Recredentialing applications are available through West Virginia Offices of the Insurance Commissioner website at wvinsurance.gov/Default.aspx?tabid=352 or through CAQH, if you are a member of CAQH.

**OH Practitioners:** As of September 2008, The Health Care Simplification Act HB125, requires all Ohio physicians to submit the CAQH form. The Health Plan subscribes to CAQH; therefore, can retrieve the practitioner’s application from the CAQH website. If the practitioner has not yet completed their initial application through CAQH, they may access the application electronically through the CAQH at caqh.org/.

**OH Ancillary Providers:** secured.insurance.ohio.gov/forms/INS5036.doc

If the practitioner is unable to obtain these forms electronically, please contact Provider Relations at 1.800.624.6961 and these forms will be sent to you via secure fax, email, or certified mail.
Standards for Participation

To become a Health Plan provider, a physician must be credentialed and meet the standards of participation, as developed by The Health Plan, in association with participating physicians. A physician must have the following credentials:

- Drug Enforcement Administration registration number if the scope of practice would warrant the physician to have a DEA.
- Professional liability - Minimum amount of 1 million, any amount below minimum will be reviewed by the Credentials Committee.
- Admitting privileges at a participating hospital.
- Clear report from the National Data Bank.
- Board-certified or board-eligible. If not board-certified or board-eligible, the physician must demonstrate appropriate training for specialty listed.
- Signed and dated agreement.
- Site survey conducted on all initial applicant’s offices.
- Proof of current medical license(s).
- Sufficient information concerning any malpractice actions.
- NPI number and UPIN number.
- Completed application.
- Completed Provider Ownership Disclosure Form.

Practitioners/providers eligible for participation with The Health Plan are:

- Medical doctors
- Doctors of osteopathy
- Doctors of podiatric medicine
- Doctors of dental surgery
- Doctors of chiropractic medicine
- Audiologist
- Certified nurse practitioners
  (Must be under the supervision of a participating physician and/or possess a Prescriptive Authority Agreement with a participating physician)
- Certified nurse midwives
  (Must have a collaborative agreement with an obstetrician)
- Physician assistants
  (Must be under the direct supervision of a participating physician)
- Independent physical therapists
- Optometrist
- Fully-licensed psychologist
- Clinical licensed master social worker
- Ambulance providers
- Durable medical equipment (Must be accredited and possess a Surety Bond)
- Independent speech language pathologist

Provider/facilities eligible for affiliation in the Health Plan Network are:

- Ambulatory surgical centers (Must be accredited)
- End-stage renal disease facilities
- Federally-qualified health centers
- Rural health clinics
- Home health care facilities
- Hospitals
- Long-term acute care hospitals
- Outpatient physical therapy facilities
- Skilled nursing facilities

Providers and facilities must meet certain requirements to be a participating provider with The Health Plan. Please contact our Network Development Department or Provider Relations Department for specific requirements.

The agreement will not be executed on behalf of The Health Plan until the credentialing process has been completed and the practitioner has been approved for participation.

Notification of acceptance and/or rejection will be sent, in written form, within 60 days of the decision.

The Health Plan will complete the credentialing process 90 days of receipt of the application or 180 days from the date of signature on the attestation statement of the application.

In addition to the above credentials, The Health Plan Quality Improvement Committee have identified the following behaviors and expectations for Health Plan physicians, who should:

- Have 24-hour availability, seven days a week, with backup coverage.
- Accept members of any or all Health Plan products, as required by Health Plan.
- Admit Health Plan patients to participating hospitals.
- Accept and support Health Plan policies.
- Allow medical records and office to be reviewed as part of collaborative quality program.
- Have records and office meet criteria established by Health Plan and participating physician.
- May not discriminate against Health Plan patients or “de-market” Health Plan.
- Admit under own service to participating hospitals if patient’s condition is within physician’s range of expertise and scope of privileges.
- Meet the CME requirement that is required for state licensure.
The following guidelines are for PCP only:

A PCP shall be required to provide a minimum of 20 hours per week of patient care availability in a county to be considered as a PCP in that county. The only exception shall be practitioners who provide services at multiple sites.

In the instance of multiple sites, these shall be acceptable providing the alternate location is within 30 miles or 60 minutes driving time of the primary location and the alternate location meets all the necessary requirements, as determined appropriate by the Credentials Committee and/or the Executive Management Team. The PCP must also provide coverage 24 hours a day, seven days per week and have privileges at a provider facility or have arranged with a contracting provider to handle all inpatient care for his/her patients.

The PCP maintains at least 50 percent primary care practice.

The following guidelines are for specialty providers (specialists and secondary care physicians):

Specialist practitioners who provide patient care access fewer than 20 hours per week in a Health Plan county shall be considered as a provider practitioner in that region, only if the specialty service of the physician is not otherwise available through sufficient plan providers residing in that region. Furthermore, the ability of the specialist to provide the necessary service locally including inpatient care, surgery and backup support shall be considered by the Credentials Committee and/or Executive Management Team in making the determination of the acceptance of the practitioner as a plan provider.

The committee shall consider the specific needs of the specialty and how the physician will accommodate his/her patient needs. Practitioners who provide only limited services locally shall not be permitted to be accepted as a plan provider. In addition, if it is determined that the physician specialty requires the physician to be available locally, the practitioner shall not be accepted as a plan provider.
Initial Certification

During the credentialing procedure, information that the physician submits to The Health Plan as part of the application process is verified. This information includes, but is not limited to, medical licensure, board certification, plus the credentials listed in a previous section. In addition, each physician must take part in an office site survey. Applicants and their practices are reviewed using certification standards developed by The Health Plan and approved by physician committee.
Practitioner’s Rights

Practitioner has the right to review all information submitted to The Health Plan in support of the credentialing / recredentialing application.

Practitioner has the right to correct erroneous information.

Practitioner has the right, upon request, to be informed of the status of their credentialing or recredentialing application.
Medical Records and Confidentiality Statement

To ensure that a separate comprehensive medical record is created and maintained in a confidential manner for each member, as well as to provide easy access to all biographical and medical information and to promote quality care.

All participating physicians and providers shall maintain a separate onsite and up-to-date member medical record in accordance with The Health Plan Standards for Patient Records, as well as compliance with all federal and state laws and regulations which are consistent with all federal and state laws and regulations, which are consistent with good medical and professional practice.

All physicians shall preserve all records related to members for a period of not less than 10 years and retain longer if the records are under review or audit.

The medical records shall be made available, as needed, to each physician treating the member. These records will be made available upon request of an authorized representative of The Health Plan for medical audit, utilization review, fiscal audit, and other periodic monitoring.

All medical records and discussion of details regarding patient information shall be confined to that which is necessary to complete normal job duties. Such discussion outside regular working duties and home is strictly prohibited.

Members shall have the opportunity to approve or deny the release of identifiable personal information by the physician or the provider except when the release is required by law. Member information shall not be released without signed authorization.

Copying of member medical records and other data containing patient information shall be kept to the minimum that is needed to accomplish work. Member information, whether personal or medical, shall be released only when necessary.

All member’s medical record information shall be kept confidential.

- All files have limited access and not left open where someone could casually read them.
- Computer system files require special password capability for access. All computer terminals accessing the mainframe shall be logged off at the close of each day to prevent unauthorized access to system data.

All member medical records requiring disposal shall be placed in appropriate receptacles for shredding. Burning may be used in lieu of shredding.

All physicians shall require the review of this policy with any new employee, and with all employees on an annual basis.
Physician offices should sign all entries in patient’s charts either by a signature or initials (full name and title). When initials are used, a record of the initials along with the person’s name should be kept on file in each office.

For your convenience, we have devised a “Signature Log” for your use. The form contains the following sections:

**Legible name** — Print the employee’s name.

**Credentials** — MD, DO, DPM, DDS, CNP, NP, PA, etc.

**Legal signature with credentials** — Have the employee sign their name with credentials.

**Any signature variations** — Employee signature if different from their legal signature.

The signature log form may be reproduced.

Onsite visits of physician offices will be conducted spontaneously to review charts, office procedures, hazardous waste disposal, and pharmaceutical and narcotic storage.

The Provider Relations Department attempts to educate offices regarding these areas as we receive additional information. It is the office’s responsibility to implement these procedures.
Telephone Message Form

At the request of many offices, we have devised a “Telephone Message Form” for your use. This form contains the necessary information needed to document phone calls received from patients. It provides space for recording times and intervention that may be important. By using this form, you may reduce the number of messages contained in your charts.

In today’s legal climate, it is increasingly important to document accurately and in a comprehensive manner. One office had indicated that a form such as this afforded them the protection and documentation necessary to defend their office against a liability claim.

Use of this form is recommended but not mandatory.